STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 88617-001-SF**

v

Blue Cross and Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 29th day of April 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On March 19, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq*. The Commissioner reviewed the request and accepted it for external review on March 26, 2008.

Under Section 2(2) of Act 495, MCL 550.1952(2), the Commissioner conducts this external review as though the Petitioner was a covered person under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on April 2, 2008.

The Petitioner is enrolled for health coverage through the Michigan Public School Employees Retirement System (MPSERS), a self-funded group. BCBSM administers the plan.

The issue in this external review can be decided by a contractual analysis. The contract involved here is the MPSERS/BCBSM "Benefit Guide", the document that describes the Petitioner's coverage. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

On January 22, 2007, the Petitioner was admitted to The XXXXX in XXXXX with a diagnosis of acute appendicitis. Surgery was performed by Dr. XXXXX who was assisted by XXXXX, a certified surgical assistant, or "CSA". Neither individual is a participating provider. The charge for Dr. XXXXX's services was $6,655.00. CSA XXXXX charged $1,254.40. BCBSM paid $1,533.09 of Dr. XXXXX's bill and nothing for CSA XXXXX's charge.

The Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on January 25, 2008 and issued a final adverse determination on February 7, 2008.

III
ISSUE

Is BCBSM required to pay an additional amount for the Petitioner's January 22, 2007 surgery?

IV
ANALYSIS

Petitioner's Argument

The Petitioner does not think she should be penalized for using a nonparticipating provider since she had no choice as to who would perform her emergency surgery. She says she was so ill at the time she was taken to the hospital; she was not able to consider issues such as whether the surgeon was a BCBSM-participating provider. The Petitioner requests that BCBSM be required to pay an additional $6,376.31, which represents the balance of the surgeon's charged and the amount charged by CSA XXXXX.

BCBSM's Argument

BCBSM says that its Benefit Guide clearly states that it pays the BCBSM-approved amount for covered services. It does not guarantee that charges will be paid in full. Since the surgeon in this case does not participate with BCBSM or BCBS of XXXXX, he is not required to accept BCBSM's approved amount as payment in full. BCBSM also notes that there are payment limits for multiple surgeries. Finally, BCBSM states that technical surgical assistance is only paid if provided by a physician and CSA XXXXX is not a physician.

The amounts charged by the surgeon and CSA and the amounts paid by BCBSM for the January 22, 2007 surgery are listed below.

Procedure Code	Amount Charged	Maximum Payment Level	Amount Approved	Amount Paid	Balance
99222	$375.00	$140.75	$140.75	$140.75	$234.25
44970	$3,077.00	$657.44	$657.44	* $328.72	$2,748.28
44180	$3,203.00	$1,063.62	$1,063.62	$1,063.62	$2,139.38
44970(CSA)	$614.00	$131.40	$131.40	** $0.00	$614.00
44180(CSA)	$640.00	$212.72	$212.72	** $0.00	$640.00
Total	$7,909.00			$1,533.09	$6,375.91

* BCBSM pays 50% of the approved amount for this service in accordance with the national standard rules recognized by BCBSM on multiple surgeries provided on the same day by the same physician.

** BCBSM did not pay for the CSA services because Mr. XXXXX is not a physician as required by the guide.

The maximum payment level for each service is determined by a resource-based relative value scale (RBRVS), a nationally recognized reimbursement structure developed by and for physicians. The RBRVS reflects the resources required to perform each service and is regularly reviewed to address the effects of changing technology, training, and medical practice.

BCBSM contends that it has paid the proper amount for the Petitioner's care and is not required to pay more.

Commissioner's Review

The Benefit Guide describes how benefits are paid. It explains on page 13 that if an individual uses a nonparticipating provider, "You pay cost difference between provider charge and Blue Cross-approved amount." In addition, the Benefit guide, on page 25, indicates that technical

surgical assistance, to be covered, must be "provided by another physician when requested by the operating surgeon."

BCBSM paid for the Petitioner's surgery based on the national standard that pays 100% of the approved amount for primary procedures and 50% of the approved amount for any secondary procedure performed on the same day by the same surgeon. BCBSM also denied coverage for the CSA since he is not a physician as required by the guide. Nothing in the record establishes that BCBSM is required to pay an additional amount for this care.

It is unfortunate that the Petitioner was not able to use a participating provider. Nevertheless, there is nothing in the language of the guide that requires BCBSM to pay more than its approved amount (or 50% of the approved amount for secondary procedures) to a nonparticipating provider, even if the care was provided on an emergency basis or no participating provider was available.

The Commissioner finds that BCBSM is not required to pay any additional amount for the surgery provided the Petitioner on January 22, 2007.

V
ORDER

BCBSM's final adverse determination of February 7, 2008, is upheld. BCBSM is not required to pay an additional amount for the Petitioner's surgery.

This is a final decision of an administrative agency. A person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. See MCL 550.1915(1), made applicable by MCL 550.1952(2).

A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.